Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SAMUEL J ALIANELL MD
25810 OAK RIDGE DRIVE
THE WOODLANDS TX 77380

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-10-4125-01

MFDR Date Received
MAY 20, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On the date of June 3, 2009 Requestor's employee Natasha Johnson contacted adjuster Avon Jackson and obtained a verbal preauthorization to render an electrodiagnostic stuy unto [Claimant]."

Amount in Dispute: $750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 16, 2009	CPT Code 95904 (x6)	$750.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600, effective May 2, 2006,requires preauthorization for specific treatments and services.
3. 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 19-(197) Precertification/authorization/notification absent.

Issues

Does a preauthorization exist in this dispute?

Findings

28 Texas Administrative Code §134.600(p)(12) requires preauthorization for "treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier."

The requestor billed CPT code 95904 for the diagnosis 729.5-Pain in limb.

According to the Neck and Upper Back Chapter of the Official Disability Guidelines (ODG), nerve conduction studies are "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy"; therefore, the disputed nerve conduction studies, CPT code 95904, required preauthorization.

The requestor submitted a copy of the Patient Profile report to support preauthorization was obtained which indicates "6/3/09 Spw adj Okay res/nec for EMG-NJ." 28 Texas Administrative Code §134.600(j) states "The carrier shall send written notification of the approval or denial of the request within one working day of the decision." This report does not support preauthorization was obtained per 28 Texas Administrative Code §134.600(j). As a result, a preauthorization issue exists and reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/24/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.